

MDR Tracking Number: M5-04-1125-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on December 18, 2003.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits (99215/99213), joint mobilization (97265), therapeutic activities (97530), myofascial release (97250), neuromuscular re-education (97112), ROM measurements (95851), and ultrasound therapy (97035) were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On March 17, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 19 days of the requestor's receipt of the Notice.

Review of the requestor's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed services will be reviewed according to the 1996 Medical Fee Guideline.

- CPT Code 95831 for dates of service 03/13/03 and 05/27/03. EOBs were not submitted. Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(E)(4) reimbursement in the amount of \$58.00 (\$29.00 x 2) is recommended.
- CPT Code 97530 for dates of service 03/31/03, 04/02/03 and 04/04/03. EOBs were not submitted. Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(A)(11)(b) reimbursement in the amount of \$105.00 (\$35.00 x 3) is recommended.
- CPT Code 99213 for date of service 04/04/03. An EOB was not submitted. Per the 1996 Medical Fee Guideline, Evaluation & Management (IV)(C)(2) reimbursement in the amount of \$48.00 is recommended.
- CPT Code 97250 for date of service 04/04/03. An EOB was not submitted. Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(C)(3) reimbursement in the amount of \$43.00 is recommended.
- CPT Code 97265 for date of service 04/04/03. An EOB was not submitted. Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(C)(3) reimbursement in the amount of \$43.00 is recommended.
- CPT Code 97112 for date of service 04/04/03. An EOB was not submitted. Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(A)(10)(a) reimbursement in the amount of \$35.00 is recommended.
- CPT Code 95851 for date of service 05/27/03. An EOB was not submitted. Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(E)(4) reimbursement in the amount of \$36.00 is recommended.
- CPT Code 99070 for date of service 07/21/03. An EOB was not submitted. Per the 1996 Medical Fee Guideline, General Instructions (IV) any single supply that is billed at \$50.00 or greater must meet DOP criteria. Per the 1996 Medical Fee Guideline, General Instructions (III)(A)(1-3), health care provider did not meet the criteria requirements. Reimbursement is not recommended.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in

Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 03/13/03, 03/31/03, 04/02/03, 04/04/03 and 05/27/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 19th day of January 2004.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf
Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DECISION

March 11, 2004

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-04-1125-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained an injury on ____ when he was struck by a cement truck while he was bending over. He saw a chiropractor for treatment and therapy. An MRI performed 08/30/03 revealed a right sided disc bulge at L5-S1 with foraminal narrowing. He received treatments including anti-inflammatory and analgesic medications and lumbar epidural steroid injections.

Requested Service(s)

Therapeutic exercises, myofascial release, therapeutic activities, neuromuscular re-education, manual traction, office visits, physical medicine procedure, and massage from 12/18/02 through 09/25/03

Decision

It is determined that the therapeutic exercises, myofascial release, therapeutic activities, neuromuscular re-education, manual traction, office visits, physical medicine procedure, and massage from 12/18/02 through 09/25/03 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The rationale of the provider to implement continued passive therapeutic algorithms in the management of this patient's medical condition is not clear. The patient was clearly in need of progression to more invasive applications following 12 weeks of care with the provider. Referrals were made for surgical consultations and pain modulation applications from 09/10/02 through 12/19/02. It is also evident that the patient had some psychological deficits and counseling sessions were warranted from 03/21/03 through 08/13/03. Further, this patient was progressed to upper level therapeutics that included work hardening. The rationale for regression to a passive unidisciplinary therapeutic algorithm in the management of this patient is not clear from the reviewed medical records and not applicable in the treatment of this worker.

It is vital to the management of this patient that a clear transition to active, patient-driven therapeutics is realized. There is no clear transition to active therapeutics noted in the reviewed medical record. The patient was progressed through biopsychosocial models, moved to upper level therapeutics, and then regressed to passive therapeutics. This is very atypical among rehabilitation professionals and is not warranted. Therefore, it is determined that the therapeutic exercises, myofascial release, therapeutic activities, neuromuscular re-education, manual traction, office visits, physical medicine procedure, and massage from 12/18/02 through 09/25/03 were not medically necessary.

The aforementioned information has been taken from the following guidelines of clinical practice and clinical references:

- *Guidelines for lumbar fusion (arthrodesis)*. Washington State Department of Labor and Injuries; 2001 Jun. 6p.
- Kankaanpää M, Taimela S, Airaksinen O. *The efficacy of active rehabilitation in chronic low back pain. Effect on pain intensity, self-experienced disability, and lumbar fatigability*. Spine. 1999 May 15;24(10):1034-42.

- Karjalainen K, et al. *Multidisciplinary biopsychosocial rehabilitation for subacute low back pain among working age adults*. Cochrane Database Syst Rev. 2000;(3)CD002193.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm